

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$3,986.27 for date of service, 08/09/01.
- b. The request was received on 08/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. UB-92 (s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Medical Records
 - e. Contract information
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/12/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/13/02. The response from the insurance carrier was received in the Division on 09/20/03. Based on 133.307 (i) the insurance carrier's response is timely.
3. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

II. PARTIES' POSITIONS

1. Requestor: Letter dated 09/10/02

“(Requestor) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by (Requestor) is at a minimum of 70% of billed charges. This is supported by a managed care contract with (healthcare plan) that is attached as Exhibit 1. This managed care contract supports (Requestor's) argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable. This managed care

contract exhibits that (Requestor) is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers [sic] medical services. As a result, the reimbursement requested by (Requestor) is not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract attached....the treatment rendered was reasonable and necessary in accordance with the usual and customary standards of the medical community for the treatment of the compensable work-related injury and under the appropriate Treatment Guidelines."

2. Respondent: Letter dated 09/20/02

"The dispute in this case is in regard to the Requestor's entitlement to additional reimbursement for facility charges associated with the following procedures performed 08/09/01: CPT Code 64442-Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level and 64443- paravertebral facet joint nerve, lumbar, each additional level [sic] (two levels). The Requestor billed \$5116.43 as a facility fee. (Respondent) paid \$1130.16.... The Requestor has failed to establish that its charges and the reimbursement that it seeks is fair and reasonable and complies with the Texas Workers' Compensation Act or TWCC Rules."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/09/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$5,116.43 for services rendered on the date of service in dispute above.
4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$1,130.16 for services rendered on the date of service in dispute above.
5. The Carrier's EOBs denied any additional reimbursement as "907- N-Not appropriately documented/Texas required bill identification; 369-This service has been reviewed per the adjustor's request; 502-F-Fee Guideline/Reimbursement is based on the coding for services rendered according to documentation submitted; 499-F-Fee Guideline/This line reflects the appropriate reimbursement; 705-M-No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area; 5-G- Unbundling/Reimbursement based on or included in the basic allowance of the appropriate procedure."

6. The amount in dispute is \$3,986.27 for services rendered on the date of service in dispute above.
7. The Requestor's position statement indicates, "...the enclosed EOB's establish that reimbursement was exponentially higher for treatment and services at or below the level of intensity of the services in dispute without any indication of any deviation from the usual method of determining the rate of reimbursement". However, no example EOBs were found in the dispute packet.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology. The denial code "G" will not be addressed since this is a facility fee dispute that incorporates all services. The only denial code that is applicable is the "M" since Ambulatory Surgical Centers are reimbursed at fair and reasonable per Rule 134.401 (a) (4). The Requestor also indicates that they were aware of the reason for denial prior to filing for dispute resolution.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"

(Carrier's Third Party Administrator [TPA]) methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. (Carrier) averaged the payments in each level for the 6 states and

designated this as the base fee for each intensity level. (Carrier) also takes into account local economic factors and applies HCFA's wage index factor to the base fees. If the specific area is not addressed in the wage index, (Carrier) uses the state average.

The Carrier sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers' compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing.

The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences. Attachment D shows samples of Texas ASCs reimbursement.

The Carrier provided a list of Texas ASC centers (bills processed in May and June 2000) that have been paid based on their methodology. The Carrier also indicates that it has canvassed other payers in the system who reimburse on the average of 110% to 140% of Medicare allowable rates and even though the Carrier does not use Medicare, it compares favorably because it pays an average of 150% of Medicare.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. As the requestor, the health care provider has the burden to provide documentation that "...discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement..." pursuant to TWCC Rule 133.307 (g) (3) (D). The requestor has failed to submit documentation that "...discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement..." Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d).

The Provider, who has the burden as the Requestor, to prove its fees are fair and reasonable only submitted a copy of a managed care contract indicating payment of 70% was expected. However, that contract is 10 years old. It does not provide current information. Also, the Requestor indicated in its position statement that there were EOBs attached as evidence that the carrier had paid at 85%. However, those EOBs were not in the dispute packet. The Provider has not provided sufficient information that supports its fees billed are fair and reasonable. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 4th day of April 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division
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